to protect both vulnerable patients and surgeons from undue physical and emotional harm, including the moral injury that accompanies the struggle to balance conflicting values. Hospital systems must ensure that access to the OR is provided in a fair and equitable way that does not exacerbate existing disparities in health care delivery for patients and surgical services alike.

DISCLOSURE

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Response to "Separate and unequal: Pandemic-related disparities in operating room access"

To the Editor:

We would like to thank Drs. Russo and Jurkovich for their thoughtful response to our recently published article highlighting the early effects of the COVID-19 pandemic on the emergency general surgery (EGS) population of the New York City Health + Hospitals network, the nation's largest municipal hospital system. Our goal was to describe the impact of statewide quarantine measures on EGS admissions and mortality during the first wave of the pandemic. We observed both a significant decrease in admissions and a significant increase in mortality for EGS patients, both coinciding with the peak of COVID infection rates in our cohort. Their letter raises several excellent points that we would like to discuss.

In our original discussion, we postulated that delays in initial presentation may have resulted in advanced disease and higher severity of illness. Our colleagues raise the question of whether prolonged time to procedure may explain our observed increase in mortality. However, because of the constraints of our available data, we were not able to analyze any factors after admission that may have produced further delays in care. We agree that timely surgical treatment can often be limited by staffing issues, particularly in the context of overnight and weekend shifts. As the burden of these "add-on" cases continues to fall on after-hour providers, optimal triage and scheduling of urgent EGS cases remain a challenge.

More importantly, our colleagues suggest that the negative impact of the pandemic is merely a symptom of larger, more longstanding issues in our existing health care system. This is a sentiment that we agree with wholeheartedly. The mission of New York City Health + Hospitals is "to deliver high quality health services with compassion, dignity, and respect to all, regardless of income, gender identity, or immigration status."[1] The overwhelming majority of our EGS patients falls under the category of high social vulnerability and face multiple obstacles to equitable health care delivery and access. Although the cancellation of elective surgery may have clinically upstaged a subset of patients into the EGS category, in our experience, many patients with surgical disease have never been evaluated by a surgeon before coming to the emergency department. While not specific to the EGS population, data from our neighboring hospitals before the pandemic report not only a high percentage of patients diagnosed with cancer in the ED but also worse surgical outcomes associated with inpatient as compared with outpatient resection.[2] We suspect that these patients may not have thought to seek out care in a nonurgent setting or were perhaps thwarted by any number of barriers to primary care. While hospital systems have a duty to provide equitable delivery of surgical therapies to all patients, further work must be done to expand access to the system overall.

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